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## Abstract

**Introduction:** Despite indications that therapeutic interaction is beneficial for patients and for nurses' job satisfaction in acute psychiatric care, research shows a **small amount** of nurses' time is spent on such activity.

**Aims:** This study investigated the actual and potential therapeutic role of the mental health nurse in psychiatric intensive care, where admission is due to violence or aggression.

**Methods:** In a mixed-methods concurrent triangulation design, **clinician** and patient activity was observed using a structured measurement tool, and qualitative interviews were conducted with four practitioners and six patients. Findings were generated using thematic analysis and descriptive statistics.

**Results:** Of the directly observed 234 **clinician** and 309 patient activities, 20.9% and 15.9% respectively were classified as therapeutic engagement. Interviews revealed that both **clinicians** and patients wanted more therapeutic contact, but whereas nurses wanted longer time to spend in individual sessions, patients preferred brief but more frequent interaction with nurses.

**Discussion:** This study shows disparity between actual and desirable levels of therapeutic interaction. Apart from organisational constraints, a fundamental problem is the lack of definition or established practices of therapeutic engagement.

**Implications for Practice:** There should be more emphasis on therapeutic engagement in nurse education, ward management and **clinical** supervision.

**Keywords:**

Mental health nurse, mixed methods, nurse-patient interaction, psychiatric intensive care, psychiatric nurse, therapeutic engagement

### **Relevance Statement:**

This study of a psychiatric intensive care unit (PICU) is the first to examine nurses' therapeutic role within a PICU environment. We consider this work to be highly relevant to nursing practice as the research is clinically focused and draws upon both nurses' and patients' experiences of therapeutic engagement within a PICU. Mental health services have gone through a radical transformation over the past 30 years with ever growing pressures on inpatient services, and as such, we have examined the therapeutic role of the nurse within the context of these changes and set out clear implications for practice and research.

### **ACCESSABLE SUMMARY**

#### **What is known on the subject**

- Mental health services have been radically transformed since the 1990s, with an emphasis on care in the community. However, acute psychiatric wards remain an important component of service provision. Research shows that patients receive limited therapeutic interaction with nurses in such settings.

- A recent review showed that just 4-12% of nurses' time was spent on activities that could be considered therapeutic.

#### **What this paper adds to existing knowledge**

- Whereas nurses wanted more time for individual therapeutic activity, patients were content with brief interactions. However, such contact was not always available, partly due to workload pressures.
- Both nurses and patients believed that a collaborative approach, involving the whole multidisciplinary team, was key to the success of therapeutic engagement
- The meaning of therapeutic engagement remains nebulous

#### **What are the implications for practice?**

- Nurse education, ward management and clinical supervision should have greater emphasis on therapeutic engagement
- Further research is needed to develop therapeutic engagement in acute psychiatric settings; such work should involve patients as active and equal partners

## Introduction

Therapeutic relationships have long been regarded as the essence of mental health nursing, as formulated in Hildegard Peplau's book *Interpersonal Relations in Nursing* (1952).

Research shows that lack of engagement may have adverse clinical outcomes for patients, for example increased violence and aggression (Chaplin *et al.* 2006) and absconding from wards (Bowers *et al.* 1999). Collins and colleagues (1985) found that inpatients who were socially engaged adjusted better to community life three months post-discharge. Further, Thomson & Hamilton (2012) found that nurses who spent the most time engaged therapeutically with patients were more satisfied with their job. It appears that nurses who spend more one-to-one time with patients take fewer sick days (Dodds & Bowels 2001); this has implications for reducing the costly use of agency nurses, who do not know patients. Therefore it is reasonable to conclude that patients, nurses and their organisations may benefit from an increase in therapeutic engagement.

Despite this, there are concerns surrounding the limited amount of time that nurses spend talking to patients (Goulter *et al.* 2015). Several studies have examined therapeutic engagement on acute psychiatric wards using either quantitative (Whittington & McLaughlin 2000) or qualitative (Cleary *et al.* 2012) methods. However, there is a need for integrative study designs to triangulate observational data with perspectives gained from qualitative enquiry. Also, there is a paucity of research on therapeutic engagement in psychiatric intensive care units (PICU), where patients have a higher level of mental disturbance.

## Background

### Therapeutic engagement: the nurses' role

According to Cormack (1976), therapeutic engagement is an intervention whereby nurses use verbal interchange to improve patients' mental health. Although therapeutic engagement appears synonymous to the therapeutic relationship, the former is an activity that may initiate or enhance the latter. As well as an opportunity for patients to discuss their treatment or other matters openly (Thomson & Hamilton 2012), therapeutic engagement is a purposeful endeavor, requiring time, skill and commitment from the practitioner. Mental health nurses are the largest health profession within mental health services (Baker *et al.* 2010). They provide the majority of direct patient care, particularly in inpatient settings (Department of Health [DH] 2006), however specifically defining their role has remained elusive. The national job profile for nursing services (NHS Employers 2006) states that mental health nurses assess, plan and implement care, maintain records and carry out nursing procedures. More specifically, communication and relationships are mentioned as imperative skills, however this still leaves room for interpretation on how to specifically carry out therapeutic engagement within the remit of the nurse's role. This may go some way to explaining why therapeutic engagement does not happen to levels desired by patients and nurses.

A study of acute wards by Radcliffe & Smith (2007) showed that at any time during the day an average of 84% of patients were socially disengaged. Further, in their review of 13 studies measuring nurse-patient interaction in psychiatric wards, Sharac *et al.* (2010) found

that while an average of half of nurses' time was spent with patients, only around 4-12% of this entailed therapeutic activities; interactions with nurses were mostly brief and instrumental. Conversely, a qualitative review that explored nurse-patient interaction on acute psychiatric units (Cleary *et al.* 2012) argued that while nurses may not be seen to be interacting therapeutically with patients, much of the work they carry out behind the scenes contributes to the therapeutic wellbeing of patients.

### **Barriers to therapeutic engagement**

Low staffing levels, administrative demands and restrictive measures to maintain safety (Thomson & Hamilton 2012; Csipke *et al.* 2014) are cited as barriers to therapeutic engagement. With bed numbers declining, only the most acutely unwell people are admitted to inpatient units (Royal College of Psychiatrists [RCP] 2009). However, a major factor in therapeutic activity is the motives and attitudes of nurses. In her seminal study of nursing, albeit in a general hospital, Isabel Menzies (1960) described how nurses unconsciously maintain a social defence mechanism. According to Menzies, nurses protect themselves by limiting their personal exposure to distress, with the result that patients who need most attention receive the least. Task-orientation, therefore, may be understood as a means of coping with the stressors of nursing.

Handy (1991) explored how mental health nurses deal with conflict between their caring and controlling functions. Although patients are potentially a source of satisfaction for nurses, the psychiatric system does not support such engagement. Handy heard that novice nurses were deterred from getting involved in patients' personal problems by more experienced nurses, for whom engagement appeared futile. Instead, nurses derived comfort

from an established order, thus maintaining the impersonal regime that ultimately causes dissatisfaction. Handy disagreed with nurses who attributed lack of therapeutic activity to staffing levels. The real issue, she argued, was the underlying discrepancy between care ideals and administrative efficiency. Until this conflict is resolved at organisational level, nurses would continue to avoid therapeutic engagement.

### **Philosophy of nurse-patient interaction**

Existential philosopher Martin Buber (1937) explained human existence as a relational phenomenon. He differentiated relationships as instrumental or commitment. The former is an 'I-it' approach, which objectifies the other person for the purpose of a task or transaction. By contrast, 'I-thou' is to engage in the other person's subjective being. Committed interaction is not merely an exchange of words, but a genuine, meaningful dialogue; in the caring context, it is a purposeful, nurturing endeavour. Buber's work provides a lens to interpret therapeutic engagement in psychiatric care.

### **Psychiatric intensive care**

PICUs are provided in many mental health trusts in the UK. The purpose of PICUs is intensive care and treatment of patients with severe mental disturbance, who need a more structured and secure environment than conventional acute psychiatric wards (Bowers *et al.* 2008). PICUs vary in principles and practice (NHS Institute for Innovation and Improvement 2008), but generally have a higher ratio of nurses, with all patients detained under the Mental Health Act (1983) (Beer *et al.* 2001). Normally patients stay for a brief period of treatment and are transferred to a conventional psychiatric ward when safe and appropriate. Working in PICUs is stressful (Björkdahl *et al.* 2010), with PICU nurses more



exposed to violence than their counterparts in acute wards (Loubser *et al.* 2009), while patients complain that medication and physical restraint is used excessively (RCP 2007).

## **The study**

### **Aim**

To investigate the actual and potential therapeutic role of nurses in a psychiatric intensive care environment.

### **Objectives**

- To measure actual therapeutic activity by nurses and received by patients through use of a systematic observation tool
- To explore actual and potential therapeutic role of nurses by eliciting the perspectives and experiences of **clinicians** and patients through semi-structured interviews

### **Design**

The mixed-methods concurrent triangulation design used semi-structured interviews and quantitative observations to capture the perspectives and experiences of **clinicians** and patients regarding the actual and potential therapeutic role of PICU nurses. The study was predominantly qualitative, and quantitative observations served as complementary data which informed the qualitative interviews and corroborated or opposed the emergent themes. This captured a more complete picture of therapeutic engagement.

## Setting

The study was conducted in one 14-bed male PICU in an inner-London NHS Trust. The PICU is staffed by a ward manager, 15 mental health nurses, seven care support workers, three doctors (including a consultant psychiatrist), one occupational therapist and one activities coordinator. All patients have their own room, are detained under the Mental Health Act (1983) and usually admitted from a regular acute ward following violent or aggressive behaviour. Length of stay normally ranges from six to 12 weeks before transfer to a conventional ward.

## Sample/Participants

Researcher SM, a registered mental health nurse unfamiliar to the host NHS trust or unit staff, presented the study to clinicians and patients, and also fixed posters on the ward corridor. This study had two levels of participation: observation and interview. For observation of actual therapeutic activity, the whole ward population of clinicians and patients was eligible. Participation was on an opt-out basis.

For the qualitative interviews, SM consulted the nursing team before inviting any patients to participate. Participants were given 24 hours to decide whether to participate and gave written informed consent before the interview. A purposive maximum variation sampling approach was pursued, to generate a sample with sufficient heterogeneity. Table 1 shows the eligibility criteria.

## Data Collection

All data were collected by SM from March to May 2016.

### *Observations:*

A systematic literature search found no observational instruments that measure therapeutic activity of both nurses and patients. Therefore, a data collection tool was devised by the authors for this study, informed by previous studies of nurse-patient interaction (e.g. Altschul 1972, Ryrie *et al.* 1998, Whittington *et al.* 2000, Cleary 2004, Bee *et al.* 2006, Seed *et al.* 2010, Sharec *et al.* 2010, Gunasekara *et al.* 2014, Goulter *et al.* 2015) and existing measures of nurse activity (Whittington *et al.* 2000, Lloyd-Evans *et al.* 2010a, Goulter *et al.* 2015). A draft tool was then reviewed in consultation with a patient and public involvement (PPI) group in the host NHS trust.

For comprehensive measurement, 28 observation time points were selected across all times of day and days of the week. This followed the design of a previous study of nurse activity (Lloyd-Evans *et al.* 2010a/b). Each time point was a momentary snapshot of ward activity. SM piloted the tool to test its viability and application. This resulted in an additional nurse activity ('patient-requested verbal exchange') and patient activity ('absent without leave'). The final tool included 27 nurse and 23 patient activities (supplementary table 1). Prior to undertaking observations, SM spent two days on the ward to familiarise with the environment, routines and clinicians. Such presence was also intended to reduce the Hawthorne effect, whereby behaviour of study participants changes as a result of their awareness of being watched (Boyce 2011).

At each time point, SM performed observation of nurse and patient activity by walking through communal areas of the ward and recording the number of nurses (qualified and unqualified) and patients engaged in any listed activity. Further information was sought from **clinicians** on any nurse or patient not directly observable (e.g. patient escort).

For any activities occurring simultaneously (e.g. medication administration and social conversation), SM judged which activity took precedence and recorded as such.

#### *Semi-structured interviews:*

Individual interviews were conducted on a one-to-one basis in a quiet room on the PICU and lasted 30-40 minutes. A topic guide was followed; this was based on published literature relating to nurse-patient activity, discussion about relevant questions with the ward manager, and presentation to a PPI group. The final topic guide (**supplementary file 2**) was piloted with a mental health nurse not involved in the study. Questions from the topic guide covered four areas: the nature of nurse-patient interaction, barriers and facilitators, organisational climate, and how engagement is and may be successfully achieved.

#### **Ethical considerations**

Ethical approval was obtained from a NHS Research Ethics Committee (reference 15/LO/2116). Due to patients suffering from acute mental illness, sensitivity was necessary in their recruitment and participation. The principles of the Mental Capacity Act (2005) were followed and SM consulted ward **clinicians** regarding individual patient's decision-making capacity when identifying potential participants. One patient interview was suspended and

data destroyed due to unstable mental state not apparent during initial screening.

Additionally, if SM or participants believed that observation was interfering with care, this was immediately suspended (this happened once; data were collected through staff report instead).

## **Data analysis**

### *Quantitative data*

Observational data were analysed quantitatively using an Excel spreadsheet (Microsoft 2013). Descriptive statistics (frequencies and percentages) were generated.

### *Qualitative data*

Interviews were analysed inductively by thematic analysis using NVivo 10 qualitative data analysis application (QSR International). Analysis followed the model of Miles & Huberman (2014) who describe three procedures of qualitative data analysis: data condensation, data display and drawing and verifying conclusions. Table 2 shows each stage of analysis.

**Clinician** and patient data were analysed together to capture the relational experience in a shared environment.

### *Mixing quantitative and qualitative data*

Qualitative and quantitative data were synthesised by examining the relationship between them and looking for areas where they confirmed or contradicted each other.

## **Rigour**

Table 3 gives a summary of the provisions made by the researchers to ensure credibility, transferability, dependability and confirmability of qualitative data.

Table 4 gives a summary of the provisions made by the researchers to ensure rigour of quantitative data.

## Results

Four **clinicians** (nurses:  $n=3$ , psychological therapies:  $n=1$ ) and six patients participated in the qualitative interviews. Interviewees included a mix of ethnic backgrounds. **Clinician experience ranged from <1 to 14 years since qualification, all educated to degree level with an even gender mix. Patients' diagnoses included psychosis and bipolar affective disorder.** Observations included all **clinicians** and patients present on the PICU during observation periods. No participants opted-out.

As per the concurrent triangulation design, the quantitative and qualitative data are discussed together (Creswell & Plano-Clark 2014) and the quantitative data are presented under the qualitative themes. Fifty-nine codes emerged from the initial analysis. These were summarised into eight first-level codes, then grouped into three distinct but inter-related themes:

### ***The Nature of Therapeutic Engagement***

Over the 28 time slots, a total of 234 nurse activities and 309 patient activities were observed. Table 5 and 6 show the total amount of nurse and patient contact and non-contact activities. 36.8% of nurse activities were patient-contact activities and 26.9% of patient activities were **clinician**-contact activities.

Although some activities were classified as contact activities, it should be noted that non-interactive close observations (14.1% nurses and 10% patients) and ward emergency (1.7% nurses and 1% patients) were not classified as therapeutic engagement. When these were removed from the analysis, it showed that 20.9% of nurses' activities and 15.9% of patients' activities could potentially be considered therapeutic engagement.

Qualitative data revealed it was difficult to define the therapeutic role of the nurse on the ward:

*"...peace keeper (laughs), security guard, yes...I mean sadly, some type of admin clerk..."*

**(Clinician 2)**

Despite this, four distinct forms of nurse-patient interaction emerged from the interviews: ad hoc, para-instrumental, social-recreational and dedicated engagement (A/P/S/D). These interactions were also observed (Table 7) and will be discussed individually below.

Ad hoc interactions were spontaneous and occurred without planning when nurses or patients required something from the other. For example when patients came to the nursing office for a request, or through social chitchat in communal areas:

*“If you’re on the floor, that’s time you get to kind of see patients, observe them, or just talk to them and see how they are in general conversation.” (C6)*

Para-instrumental interactions required a degree of therapeutic engagement, however often occurred alongside another nursing task, for example planning and attending a Mental Health Act Tribunal or ward round, or through interactive close observations:

*“Before the tribunal the nurses were coming to me and giving me advice, which was very helpful because when I went into the tribunal I felt I was fully loaded. I was confident. That was good” (Patient 1)*

The most commonly discussed interaction was social-recreational interactions, where nurses and patients engaged through specific activities such as playing board-games, basketball, or mealtimes. Through observation alone, these interactions may not appear therapeutic, however interviews clearly highlighted that this interaction was used as a catalyst for therapeutic engagement:

*“They’d play Connect 4 with me, we discussed, as we were doing that, that was like a medium for discussion about antagonistic sort of competition, my competitive nature.”*

(P4)

Dedicated engagement involved extended periods of one-to-one interaction where discussions surrounding patients’ mental health and recovery occurred. Nurses considered



personal interactions to be their ultimate aim, however in reality these interactions were difficult to achieve due to numerous factors which will be discussed later:

*“There’s not enough and it’s quite obvious from some of our care plans which are really brief, that we’re having fleeting conversations but we’re not putting enough emphasis on one-to-ones.” (C5)*

Although all nurses considered dedicated engagement to be the type of interaction they should aim for, some patients felt they did not require this level of input. This highlights the sometimes differing priorities of nurses and patients:

*“Unless it’s something to do with the hospital, I’ve got nothing to discuss. This isn’t a psychotherapy session...I need information, they have it.” (P1)*

A majority of patients perceived the nurses’ therapeutic role as predominantly practical information giver rather than uninterrupted one-to-ones:

*“The reason I’m here is not to give me one-to-one and ask me questions about what happened, it’s about what’s happened with my section or what’s happened with my leave.” (P7)*

Despite nurses’ wishes to deliver dedicated engagements, if done thoughtfully, patients found ad hoc, para-instrumental and social-recreational interactions therapeutic, yet profoundly detrimental if done flippantly:

*“I’d fallen asleep...one of the nurses woke me up, he basically said “you’re going, grab your things”. I had no idea he meant being brought to this ward...I thought things were going well, I might have my life back, but everything was taken away from me because he didn’t explain.” (P4)*

As patients were generally happy with the type of interaction they received e.g. A/P/S/D, this suggests that nurses often interacted in a committed manner, and embraced interactions, no matter the length, through Buber’s (1937) “I-Thou” approach. This is important, as through observations alone, nurse-patient interactions were viewed as more instrumental, “I-It” exchanges, due to their short length and the inability of the researcher to decipher exact content of interactions. However, interview data suggested that many short interactions were carried out in a committed, “I-Thou” manner and left patients feeling satisfied.

Regardless of patients’ general satisfaction with the type of interactions received, it was clear that nurses could improve the consistency of interactions. A patient example highlights how when he asked the nurses to take him out on leave – an interaction he found particularly therapeutic – this request was granted inconsistently:

*“It’s like a little bit unpredictable for me because I knock and they come and it’s like yes, no, what, maybe, sometimes, ahhh!” (P9)*

## ***The Ward as an Ecosystem***

All participants discussed the connection between nurses, patients, the multidisciplinary team (MDT) and the organisation as a whole. In this sense, therapeutic engagement could be conceptualised as an ecological issue whereby the amount and type of engagement was directly influenced by the interactions, relationships and characteristics of and between **clinicians**, patients, and the organisation. A change in any of these dynamics had the potential to either positively or negatively influence the amount of therapeutic engagement given and sought. For example if an organisation's culture emphasised paperwork that is likely to reduce nurses' availability for therapeutic engagement. This may affect certain patient factors such as their trust in nurses, which may then influence the type of engagement that is sought. Figure 1 shows this inter-related connection.

A nurse highlights this connection by explaining how a recent organisational change enabled nursing time to be freed:

*"In ward-round we see a patient then have to do paperwork for clusters, for section 132 rights, and so on...if the patient is seen by the MDT, you've got the nurse, doctor, OT, whoever therapist there, and we can discuss with the patient face-to-face and update the paperwork right away...that releases time. So currently we are changing this...the culture is changing." (C8)*

A patient gave an example by describing the link between his own mental state and the nurse's willingness to engage therapeutically:

*“...they [nurse] made an effort as much as I did, and it was probably my state of mind that allowed them to do that.” (P4)*

Another example illustrates how patients require both instrumental and committed interactions from nurses depending on their priorities for the day and what other **clinicians** are available. During the day when patients had other things on their minds, task-orientated, instrumental nurse-patient interactions were the dominant interchange. In contrast, when there were fewer distractions patients sought more committed, “I-Thou” interactions:

*“...in the morning patients have appointments, other things on their minds and the engagement then is that they want to know what time the doctor is coming in, to talk about their medication, their leave, to their solicitor, but during late shifts you don’t have as many distractions.” (C5)*

Individual nurse characteristics also influenced this fine ecological balance. Some characteristics were tangible and able to be taught while others were more difficult to quantify:

*“Oh, it’s definitely caring. It’s as simple as that. The people that care about what they’re doing. And it’s love. Love, well, love conquers everything, doesn’t it?” (P1)*

Further, some nurses, particularly recently qualified, were afraid that organisational pressures may negatively affect their inherent caring qualities:

*“...how thinly can we spread ourselves? I always try to find a balance, but it’s VERY TOUGH! It’s exhausting and demanding and sometimes if you’re not careful it can make you forget why you came into the profession...that’s the most worrying thing.”*

(C6)

### ***Finding a Better Way***

Overall both **clinicians** and patients offered potential solutions to improve therapeutic engagement. **Clinicians**, particularly, recognised that more should be done, however how best to make improvements was often unclear. Ideas varied greatly and ranged from simple changes to complex attitude shifts. Input from **clinicians**, patients and the organisation was necessary, which lends weight to therapeutic engagement being an ecological issue, where shared experience is paramount.

Power dynamics played a role in the success or otherwise of therapeutic engagement and a common suggestion from patients was for both nurses and patients to “*forgive and forget*” (P3) and not allow past incidents to taint future engagements:

*“...by working a day by day basis. Don’t think about what did I say, what did I do, that’s admission, don’t be put off by what happened before! We know it’s wrong, but*

*that was last time, you can't punish somebody for the past, that's the past, that's why we're called people!" (P7)*

Some nurses felt that increased pressure on one-to-one sessions may improve the amount of engagement:

*"Things get done because there's so much pressure on us to do them, people check, so maybe if the same pressure was put on one-to-ones they would get done." (C5)*

However, generally participants felt that conventional monitoring was complicated as what happened during one-to-ones could be misrepresented in ward progress notes:

*"You can do it by just sort of bumping into somebody in the corridor and saying how are you today and walking on, then in the notes, my one-to-one, he was asked how he was, and when you read it, it looks like a good one-to-one, but it's just a fleeting encounter." (C2)*

The central message from all participants was that working as a team inclusive of patients, nurses and the MDT was key to therapeutic engagement's success. A nurse suggested an MDT approach to combining paperwork:

*"So you have the nursing physical health assessment and the medical physical health assessment, if you combine both, one of them can go and you reduce some of the paperwork by doing certain things as an MDT." (C8)*

And a patient suggests unifying **clinicians** and patients so they feel a part of one team:

*“...group meetings, identification, maybe a ward sticker so you feel like you’re part of something...you know...that everyone wears so you’re part of a team, because then the nurse and the patient is both part of that team, they’re working together.” (P4)*

## **Discussion**

In this mixed-methods investigation we found a disparity between nurses’ and patients’ desired frequency and type of therapeutic engagement. While nurses would like time for longer interactions, patients want brief but consistently accessible contact. Data triangulation showed that many short interactions actually conveyed commitment by nurses, to the satisfaction of patients. Therapeutic activity by nurses was directly influenced by administrative demands, patients’ mental state and availability of other members of the MDT.

Despite concerns raised about insufficient nurse-patient contact in policy documents in the UK and other countries (DH 2006, Nursing & Midwifery Board Australia 2016), observation data in this study reinforces evidence of a persistent therapeutic vacuum in inpatient psychiatric care (Sharac *et al* 2010). However, interviews provided a more nuanced picture. Activities that were not primarily classified as therapeutic played an important role towards the therapeutic experience of patients. This phenomenon was highlighted by Cleary and

colleagues (2012) who found nurses often interact with patients in sophisticated ways without an explicit structure or purpose.

Like the participants in a study by Rose and colleagues (2015), nurses in our study were troubled by their lack of time for patient contact. In an attempt to increase therapeutic contact, the Mental Health Act Commission (Mental Health Act Commission 2008) recommended protected engagement time (PET), whereby a period of nurses' day (typically an hour) is dedicated for therapeutic interaction. However, there was little evidence to suggest that PET worked as intended (McCrae 2014), and it appears to have been abandoned in many NHS trusts. Therapeutic engagement cannot be enforced by rule.

The National Institute of Health & Clinical Excellence (NICE 2011) recommended that patients receive daily one-to-one sessions of at least an hour, but this may be counterproductive. An arbitrarily-set minimum period may be longer than what patients want or need. Quality of interactions is not necessarily related to the amount of time spent. The focus of engagement should be redirected from form to content, emphasising frequency, empathy and therapeutic purpose over duration. In their study on what makes an excellent mental health nurse, Gunasekara and colleagues (2014) explained that how nurses care is as important as the type of caring activity. This was echoed by participants in our study, who perceived some interactions with **clinicians** as detrimental.

An expectation to spend a whole hour with individual patients is likely to deter busy nurses from therapeutic encounters. Nurses may be distracted by events such as admissions, which are rarely planned in advance, and they have a heavy administrative burden (Sharac *et al.*



2010). The system forces nurses to complete tangible tasks but there is no disciplinary requirement for therapeutic engagement; understandably stressed nurses will focus on the work that must be done. The Royal College of Psychiatrists (2014) published standards for PICUs stipulating that daily one-to-one sessions should be documented, and that patients should receive a minimum of thrice-weekly sessions with their primary nurse. In common with previously published work (e.g. Rose *et al.* 2015), clinicians in this study suggested that written reports do not accurately record nurse-patient contact. As Donabedian (2005) asserted, ward notes should not be taken at face value when evaluating healthcare. As well as diverting nurses from patient contact, organisations fail to ensure that the frequency and quality of therapeutic activity is recorded. Consequently, nurses or managers cannot readily see the care a patient has received, including from the primary nurse. Better ways of recording nurse-patient interaction are needed.

Buber's dichotomy of instrumentalism and commitment reflects an unresolved conflict in healthcare, similar to that between person-centred care and evidence-based practice (McCrae 2013). Although these doctrines are not mutually exclusive, in practice the tangible, measurable activity often takes precedence over the more nebulous enterprise of therapeutic engagement. As Menzies' (1960) classic study showed, nurses protect themselves from patients' distress by taking refuge in instrumental endeavours. There are numerous tasks to perform in nursing, but this does not necessarily cause instrumentalism. Ideally, commitment should be displayed throughout the nursing remit, which transcends 'doing' and 'being'. Short but frequent "I-thou" (Buber 1937) interactions may reap greater benefits for patients and nurses than longer sessions, particularly if the latter are perceived as burdensome or decline to an "I-it" situation.

Acutely mentally unwell patients present with a myriad of symptoms and behaviour that can be very challenging and emotionally draining for nurses, including delusions, suspiciousness and aggression (Bowers *et al.* 2010). It is not surprising that nurses may be sparing in how much time they afford to therapeutic interaction with patients who are volatile and highly disturbed. Nurses are prone to long-term effects of stress, known as burnout. A prominent feature of burnout is depersonalisation, resulting in detachment from patients and a disinclination to build a therapeutic rapport (Wang *et al.* 2015). Clinical supervision has been shown to reduce the manifestations of burnout (Edwards *et al.* 2006). To improve therapeutic engagement, it is imperative that regular supervision is provided for nurses in acute psychiatric settings. Nurses have a finite capacity for the stress arising from meaningful therapeutic work with patients, and a safe outlet is needed. Whether supervision is provided by a senior nurse, a psychologist or through a peer group, the purpose is not merely a release valve, but to nurture resilience. This gives nurses the confidence to approach patients without fearing harm to themselves.

## **Limitations**

There are several limitations that should be considered. The observational tool was developed through consultation with experts and piloted to test its applicability and viability, but it was not tested for reliability or validity. Furthermore, awareness of the observer may have affected nurses' and patients' behaviours, although the long duration of the observation period may have reduced any Hawthorne effect (Abdellah & Levine 1954). Social desirability was possible in interviews; for example, participants may have overstated their therapeutic input or intent. A strength of this study is its triangulation of direct

observation with perspectives of patients and **clinicians**, in a setting that appears fairly representative of PICUs, at least in the British context.

## Conclusion

After decades of research and policy guidelines, no satisfactory resolution has been found for lack of therapeutic engagement in acute psychiatric wards. This study informs nurses and managers by showing that patients prefer brief and frequent interventions, rather than sessions of longer duration. The emphasis should be on consistent provision of meaningful, committed engagement, within the practical constraints of acute or intensive psychiatric care. Further research should involve patients and **clinicians** as equal and active partners to find realistic ways of boosting therapeutic engagement. This may be done through experience based co-design (e.g. Springham & Robert 2015), whereby **clinicians**, patients and researchers work collaboratively to improve quality. We recommend Buber's formulation of 'I-thou' commitment as a philosophical and practical basis for ward management, clinical supervision and nurse education.

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